Montana WIC/Medicaid Nutrition Referral Form

Complete the following:

1. Client's name: _____

2. Guardian's name (if applicable):
_____

3. Name and address of the WIC clinic:

_____

_____

_____

4. WIC phone number _____

5. Signature of WIC staff person: _____Date: _____

Check the applicable box:

☐ Client is **not** eligible for the Montana WIC Nutrition Program. Refer to Medicaid, if applicable.

☐ Client is eligible for the Montana WIC Nutrition Program **but** the requested formula is not approved for issuance through the Montana WIC program (complete this form and fax to Montana Medicaid, ATTN: Medicaid DME Officer at 406-444-1861; send a copy of this form with the participant for reference with pharmacy and PCP)

Name of the requested formula _____

*Instruct the client to go to their PCP and have them request the formula from Montana Medicaid.

☐ Client is eligible for the Montana WIC Nutrition Program **but** the medical formula and medical condition may** qualify for coverage through Medicaid as first payer (tube feed or chronic/significant medical condition which impairs nutrient absorption and is being followed by PCP, specialists and/or RD).

Name of the formula (complete this form and fax to Montana Medicaid, ATTN: Medicaid DME Officer at 406-444-1861 send a copy of this form with the participant for reference with pharmacy and PCP)

Name of formula requested_____

*Instruct the client to go to their PCP and have them request the formula from Montana Medicaid.

** Montana WIC may continue to cover WIC eligible formula until Medicaid coverage is assessed and approved. Please have a release of information on file to communicate with PCP and Medicaid to coordinate coverage of formula by the appropriate entity.